



ACUTE PROGRAMS – Screening Procedures for Acute
Psychiatric Treatment of Children Under Age 21



UNDER 21 & UTILIZATION REVIEW/CONTROL

Screening Guidelines

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Introduction and Overview


Introduction to Dual Diagnosis Management and our role in North Dakota's Screening Processes

This manual serves as a reference for behavioral health providers that treat children under age 21. In the following sections, we provide you with a description of screening requirements, screening processes, and important definitions that you will need to know in order to comply with these program requirements. Acute and residential screening requirements advocate for the individual, through promoting the least restrictive and most appropriate placement at the earliest possible time.

Dual Diagnosis Management

Dual Diagnosis Management (DDM) is a Nashville-based utilization review firm that specializes in integrated disease management directed at both behavioral and medical health care. Our staff has solid familiarity with Utilization Review processes in North Dakota as well as in a variety of states.

ICON KEY

 Valuable information

 Make Note

 Key Review Points

DDM Contact Information

Screening information can be forwarded by facsimile, mail, phone, email, or soon, by web-based submission. All phone and facsimile numbers are toll free. Contact information is as follows:

Dual Diagnosis Management
North Dakota Division
220 Venture Circle
Nashville, Tennessee 37228
Phone: 887.431.1388 • Facsimile: 887.431.9568

DDM conducts phone-based reviews both at admission and to determine need for continued care. **Phone-based** reviews are performed within 6 business hours from referral by credentialed and trained employees of DDM.



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Section

2

The Under 21 Benefit

Identification and Screening Requirements for Individuals Subject to Under 21 Utilization Review Processes

The federal government allows states the option of covering inpatient psychiatric hospital services for children under the age of 21 (known as the *Under 21* benefit). While services may be covered only for beneficiaries age 21 and under, those under 21 at the time of admission may continue receiving care, as indicated, until age 22. This under 21 benefit is applicable to:

- ✓ **Acute inpatient psychiatric units**
- ✓ **Residential Treatment** for adolescents that are accredited by JCAHO
- ✓ **Non-JCAHO Accredited RTCs**
- ✓ **Reciprocal Out of State facilities**

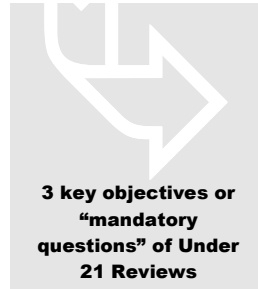
The primary function of Under 21 Reviews is advocacy – to ensure the least restrictive placement at the earliest possible time.

Through the Center for Medicare and Medicaid Services (CMS, formerly HCFA), the federal government requires that all agencies serving Medicaid populations and receiving Medicaid funds have a utilization control program that monitors the need for services before payment can be authorized. In the case of inpatient services, regulatory language mandates that inpatient psychiatric services are appropriate for individuals undergoing active treatment, in accordance with an individual plan of care intended to *"improve the recipient's condition or prevent further regression so that the services will no longer be needed."* These requirements became statutory in 1972 for Medicaid and Medicare programs.

Facilities covered by the Under 21 benefit are subject to federal guidelines in the Code of Federal Regulations (CFR), Title 42 CFR 441 Subpart D and Subpart G of 483. These guidelines describe essential federal boundaries that the State's Utilization Review/CON agency will follow to enact Certification of Need oversight requirements and to perform Utilization

LEVEL OF CARE (LOC) SCREENING PROCESS

Review for hospital and non-hospital based inpatient care. Certification of Need (441.152) guidelines require that a team specified in Section 441.154 certify that:



- (1) *Ambulatory care resources available in the community do not meet the treatment needs of the recipient;*
- (2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- (3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services

Utilization Review Types and Processes

Acute inpatient services are provided in a secured psychiatric hospital or psychiatric unit to treat symptoms so severe that the absence of psychiatric intervention could potentially result in increased serious dysfunction, death, or harm to self or others. Acute inpatient admissions occur as **either elective or emergency**.

Certificate of Need (CON) is a regulatory review process that requires specific health care providers to obtain prior authorization for provision of services for Medicaid applicants or eligible recipients.

Acute Review Types

There are three potential types of acute reviews: *admission*, *continued stay*, and *retrospective* reviews.

ADMISSION REVIEWS

Admission reviews apply to acute inpatient admissions for children under age 21 or, if the individual was receiving the services immediately before he or she reached age 21, up to the date the individual reaches 22; and for those children who apply for Medicaid prior to admission or while receiving services. Two types of admission reviews are performed:

A grey rectangular box containing a white icon of a hand with the index finger pointing to the right. Below the icon, the text reads: "DDM completes the CON for elective admissions & the provider completes the CON for emergency admissions. (See CON requirements at the end of this subsection).".

- **Elective** – A relatively sudden, short, and severe course of a psychiatric condition presenting significant and immediate danger to the recipient, others, or the public safety; or one resulting in marked psychosocial dysfunction or grave mental disability of the recipient. The therapeutic intervention and treatment of an acute admission is aggressive and aimed toward expeditiously

LEVEL OF CARE (LOC) SCREENING PROCESS

moving the recipient to a less restrictive environment.

- **Emergency** – A sudden onset of symptomatology characterized by suicidal ideations/gestures and/or homicidal ideation/gestures, and/or psychosis to the extent that imminent hospitalization is warranted and that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part, death of the recipient, or harm to another person by the recipient.

CONTINUED STAY REVIEWS

Continued Stay Reviews (CSRs) involve continued evaluation of the child's need for acute services. The CSR process re-applies the 3 mandatory questions, comparing the individual's medical need for the level of intensity in services, along with his/her continued ability to benefit from those services.

RETROSPECTIVE REVIEWS

Retrospective Reviews involve evaluating medical need for services for children who apply for Medicaid after receiving acute inpatient services.

Admission Review Process

ELECTIVE ADMISSION REVIEWS

The following occurs for acute **elective admission reviews** for Medicaid recipients under age 21.

1. The provider verifies the recipient's Medicaid eligibility or Medicaid application.
2. The provider notifies DDM by fax/e-mail within three (3) business days prior to or on the day of the elective admission.
3. The provider submits a completed *North Dakota Admission Review Request* form by fax/e-mail that includes:

Demographic information

- Recipient's Medicaid ID number (MID)
- Recipient's social security number (SSN)
- Recipient's name, date of birth, sex
- Recipient's address, county of eligibility, telephone number
- Responsible party's name, address, phone number
- Provider's name, date of admission

Clinical information

- Prior inpatient treatment
- Prior outpatient treatment/alternative treatment

LEVEL OF CARE (LOC) SCREENING PROCESS

- Initial treatment plan
 - Estimated length of stay
 - Admitting diagnoses, DSM-IV diagnosis on Axis I through V
 - Medication history
 - Precautions
 - Current symptoms requiring inpatient care
 - Chronic behavior/symptoms
 - Appropriate medical, social, and family histories
4. DDM conducts the review and notifies the provider of the determination by telephone/e-mail within one (1) business day from receipt of the review request.

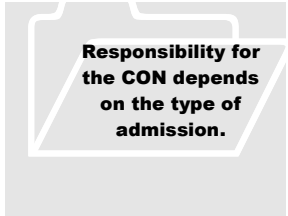
If medical necessity is met, DDM completes a CON form which accompanies the written approval notification sent to the facility.

EMERGENCY ADMISSION PROCESS

The following occurs for acute emergency admissions for Medicaid recipients under age 21 in acute inpatient treatment facilities.

1. The provider verifies the recipient's Medicaid eligibility or Medicaid application.
2. The provider notifies DDM by fax/e-mail within two (2) business days of or on the day of admission.
3. The provider submits a completed *North Dakota Admission Review Request* form by fax/e-mail that includes all information specified for *Elective Admissions*.
4. DDM conducts the review and notifies the provider of the determination by telephone/e-mail, or electronically within one (1) business day from receipt of the review request. Determinations are the same as those specified for *Elective Admissions*.

The provider must submit a completed and valid **Provider Certificate of Need** form (as described in the following procedure) **by or before 14 days of admission** as required in 42 CFR 441.152 and 42 CFR 441.153. The provider must maintain a copy of the CON form in the recipient's/applicant's medical record.



Responsibility for the CON depends on the type of admission.

LEVEL OF CARE (LOC) SCREENING PROCESS

Certificate of Need

The CON affirms that the 3 mandatory questions were answered before the child's admission.

A Certificate of Need (CON) is a federal requirement for documentation for inpatient hospitalization for Medicaid recipients under age 21 and individuals age 21 if the individual was receiving the services immediately before reaching age 21.

The CON requirements specified in 42 CFR 441.152 certify that::

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

For an individual who is a recipient when admitted to a facility or program, certification must be made by an *independent* team that:

- Includes a physician;
- Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
- Has knowledge of the individual's situation.

North Dakota Century Code (NDCC) 75-02-02-10 (3) (a) (1) stipulates that: "...an *independent review team must be composed of individuals who have no business or personal relationship with the inpatient psychiatric facility or program requesting a certification of need.*" DDM serves as the independent team that completes the CON form for Medicaid recipients under age 21 admitted as elective admissions. This team consists of a Board-certified/eligible child psychiatrist and a registered nurse (RN) with a minimum of two (2) years experience in children's behavioral health. The acute treatment provider must complete the CON for emergency admissions.

PROVIDER CERTIFICATE OF NEED PROCESS

Federal Code	Provider CON Requirement (For emergency admissions and post admission Medicaid applications for Acute inpatient and accredited RTCs)
42 CFR 441.152	<p>Provider CON must certify that:</p> <ul style="list-style-type: none">• Ambulatory care resources available in the community do not meet the treatment needs of the recipient;• Proper treatment of the recipient's psychiatric condition requires services on

LEVEL OF CARE (LOC) SCREENING PROCESS

Federal Code	Provider CON Requirement (For emergency admissions and post admission Medicaid applications for Acute inpatient and accredited RTCs)
	<p>an inpatient basis under the direction of a physician; and</p> <ul style="list-style-type: none"> The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.
42 CFR 441.153	For emergency admissions, the certification must be completed, signed, and dated by the team members responsible for the plan of care (42 CFR 441.156) within 14 days after admission (42 CFR 441.153). The team responsible for the recipient's plan of care must be employed by or provide services to patients in the facility.
42 CFR 441.156	<p>The provider team must include a minimum of two team members, either:</p> <ol style="list-style-type: none"> A Board-eligible or Board-certified psychiatrist; or A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association. <p>The team must also include one of the following:</p> <ol style="list-style-type: none"> A psychiatric social worker. A registered nurse with specialized training or one year's experience in treating mentally ill individuals. An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals. A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.



*Note about the Provider CON

Failure to complete or submit a timely CON in emergency admissions can result in a technical denial for services, regardless of the child's medical need for treatment. An admission review on a child admitted on an emergency basis cannot be processed until the Provider CON is received.

Continued Stay Reviews (CSRs)

CSRs apply to Medicaid recipients/applicants who are eligible on admission and for individuals who apply for Medicaid following admission. For Acute Inpatient Care, each CSR may permit continued Medicaid reimbursement for the inpatient stay up to 14 calendar days until discharge from the facility or until medical necessity is no longer met.

LEVEL OF CARE (LOC) SCREENING PROCESS

CSRS FOR CHILDREN WHO ARE MEDICAID RECIPIENTS AT ADMISSION

The following occurs for acute CSRs for children under age 21 who were subject to an Under 21 admission review.

1. The provider contacts DDM by fax/e-mail by one (1) business day prior to the termination of the current certification.
2. The provider submits a completed *North Dakota Continued Stay Review Request* form by fax/e-mail that includes:
 - Demographic information as specified under admission reviews
 - Clinical information
 - Current Treatment Plan
 - Changes to current DSM-IV diagnosis on Axis I through V. GAF is required for each authorization request
 - Assessment of treatment progress related to admitting symptoms and identified treatment goals
 - Summary of treatment provided to the point of review
 - Assessment/justification for continued services at this level of care
 - Behavioral Management Interventions/Critical Incident
 - Current list of medications or rationale for medication changes, if applicable
 - Projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan

3. DDM conducts review and notifies provider of the determination by telephone/e-mail or electronically within one (1) business day from receipt of the review request.

CSRS FOR CHILDREN WHO APPLY FOR MEDICAL ASSISTANCE FOLLOWING ADMISSION

For individuals applying for Medicaid during receipt of services, the following procedures apply:

1. The provider verifies the recipient's Medicaid eligibility or Medicaid application.
2. The provider notifies DDM by fax/e-mail within two (2) business days of notification regarding the individual's application for Medicaid.
3. The provider submits a completed *North Dakota Admission Review Request* form by fax/e-mail that includes all of the content requirements specified under Elective Admission reviews.
4. DDM conducts the review and notifies the provider of the determination by telephone/e-mail or electronically within one (1) business day from receipt of the review request. Acute Inpatient approvals may include authorizations in increments of up to 14 calendar days.

LEVEL OF CARE (LOC) SCREENING PROCESS

The provider must submit a completed and valid Provider Certificate of Need form with the review request and must maintain a copy of the CON form in the recipient's/applicant's medical record.

Retrospective Reviews

POST DISCHARGE MEDICAID APPLICATION REVIEW PROCEDURES

For individuals applying for Medicaid following receipt of services, the following *retrospective review* procedures apply:

1. The provider contacts DDM by fax/e-mail within two (2) business days of notification regarding the individual's application for Medicaid.
2. The provider submits a completed *North Dakota Retrospective Review Request* form by fax/e-mail **along with** the individual's medical record.
3. DDM conducts the review and notifies the provider of the determination by telephone/e-mail or electronically within three business days from receipt of the review request and medical record. Determinations and timeframes include all options discussed in the following section, in addition to expanded *deferral* options of:
 - **Deferral:** If medical necessity is not met for the entire length of stay, the case is deferred to a DDM Board-certified/eligible child psychiatrist.
 - **Approval Period:** DDM's psychiatrist makes a determination of whether the admission met standards for approval for the entire stay, partial stay, or none of the stay.

DDM makes a determination within three (3) business days of deferral or receipt of additional information. DDM notifies the provider by telephone/e-mail of the review determination within one (1) business day of the determination.

Outcomes & Notifications

The following outcomes occur as a result of the Under 21 review process.

- **Authorization (Approval):** authorization of the admission and an inpatient stay of up to 14 calendar days. Authorization will include the end date on which the authorization terminates.
- **Pending:** Determination that additional information is needed to complete the review. **The provider must submit information within two (2) business days** of the request for additional information. If additional information is not received from the provider within two (2) business days of the request, a **technical denial** will be issued.

If additional information is received within two business days of the request and

LEVEL OF CARE (LOC) SCREENING PROCESS

medical necessity is met, the authorization review is completed and the provider notified by telephone/e-mail of the review determination within one (1) business day from receipt of additional information.

- **Deferral:** If medical necessity is not met or **if the child is age 6 or under**, the case is deferred to a DDM Board-certified/eligible child psychiatrist.

For CSRs, a deferral may also occur if there are serious discrepancies or problems with assessments and/or treatment plans for the recipient (*e.g.*, unrealistic treatment plan, failure to provide appropriate assessments) or if there is a significant increase in the projected length of stay that occurs during the course of treatment.

DDM's psychiatrist reviews the information and makes a determination within one (1) business day of deferral or receipt of additional information. DDM notifies the provider by telephone/e-mail of the review determination within one (1) business day of the determination.

- **Partial Approval:** A DDM Board-certified/eligible child psychiatrist issues a partial approval determination when only a portion of a stay meets Medicaid medical necessity criteria. The Desk Reconsideration/Appeal processes apply to partial approvals.
- **Denial:** A DDM Board-certified/eligible child psychiatrist issues a denial if the request for authorization does not meet Medicaid medical necessity criteria for the services requested. The Desk Reconsideration/Appeal processes apply to denial decisions.
- **Technical Denial:** A denial of Medicaid payment because of provider non-compliance with Medicaid protocol (*i.e.*, failure to complete or submit a CON timely or appropriately, failure to submit additional information when requested, etc.).

NOTIFICATION PROCESS

DDM staff will call the referring individual within one business day of assessment completion, followed by documentation of the assessment outcome and, as applicable, appeal rights to the legal representative. A notification letter will also be forwarded to the admitting facility.



Even if a child meets criteria for treatment, if the provider fails to comprehensively complete the admission or CSR protocol, the stay may be denied Medicaid reimbursement for services.



When completing admission/CSR forms, concentrate on providing information that addresses the 3 mandatory questions.

LEVEL OF CARE (LOC) SCREENING PROCESS



If information is requested by the DDM reviewer, the provider has 2 days to submit information requests. If complete information is not received within that time period, the stay will be denied regardless of the child's medical need.

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Section
3

Acute Medical Necessity Standards

Admission and Continued Stay Screening Requirements for Individuals who Subject to Under 21 Review Processes

Each of the following criteria A – C must be met for elective admission to acute inpatient psychiatric services when reimbursement is to be made on behalf of eligible recipients of Title XIX Medicaid benefits (42 CFR 441.152). If the child is admitted through an emergency admission, in lieu of assessing the child's status against the following criteria, a determination may be made as to whether the child presented at admission as homicidal, suicidal, or psychotic.

LOC Screens apply to Medicaid eligible individuals using LTC services –and– All NF applicants & residents with MI, MR.

Acute Inpatient Admission Criteria

Criterion A: Ambulatory resources providing less restrictive levels of care that are available in the community do not meet the treatment needs of the recipient. To meet this requirement, ONE of the following three items must be established:

- (1) A less restrictive (lower) level of care will not meet the recipient's treatment needs. Examples of less restrictive levels of care include:
 - Family or relative placement with outpatient clinical services
 - Outpatient therapy
 - Group home supported by outpatient clinical services
 - Therapeutic Group home
 - Other outpatient clinical or rehabilitation services
 - Self-help groups with outpatient day treatment
 - Residential Treatment or Day Care Treatment
- (2) An appropriate less restrictive (lower) level of care is unavailable or inaccessible.
- (3) Medically necessary due to complicating co-existing mental health and physical disorders. Although the Axis III condition requires medical treatment, the co-morbid psychiatric issues on Axis I are now the predominant treatment course (e.g., Major Depression with Epilepsy; Major Depression with Insulin Dependent Diabetes; Major Depression with Renal Dialysis).

DETERMINING MEDICAL NEED FOR ACUTE SERVICES

Criteria B: Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. To meet this requirement ALL of the following four conditions must be established:

1. On or before admission, an attending or staff physician completed a medical evaluation certifying the need for hospitalization with treatment to be given under the direction of a physician.
2. The recipient has a primary diagnosis of a mental health disorder classified as a DSM IV-R Axis I diagnosis between 290-316 (excludes substance abuse disorders). Any -substance abuse disorder must be secondary to a co-existing mental health disorder.
3. The severity of symptoms rating on Axis V Global Assessment of Functioning (GAF) at admission to a psychiatric hospital is 50 or below; the GAF may be higher in cases where there is acute risk of harm to self or others or in continued stay cases where the treatment has stabilized the recipient's medical condition and the recipient is awaiting placement to an appropriate lower level of care.
4. Currently the recipient is experiencing acute disturbances related to the mental health disorder with deficits in at least one of the following established:
 - **Self-care (age appropriate):** Basic impairment in ability to meet needs for nutrition, sleep, hygiene, rest, or stimulation related to the recipient's Axis I mental disorder(s) as diagnosed in number two (2). Indicators include: Self-care deficit places recipient in life-threatening physiological imbalance without skilled intervention and supervision (e.g., dehydration, starvation states, exhaustion as a result of extreme hyperactivity or insomnia, and lack of medication compliance); Sleep deprivation or significant weight loss; Self-care deficit severe and longstanding enough to prevent participation in any alternative setting in the community, including refusal to comply with treatment
 - **Impaired Safety:** Threat to self or others caused by the mental disorder, including threats accompanied by any one of the following: depressed mood, recent loss, recent suicide attempt or gesture, concomitant substance abuse, verbalizations escalating in intensity, verbalization of intent accompanied by a gesture or plan.
 - **Impaired thought and/or perceptual processes (reality testing):** Inability to perceive and validate reality to the extent that the recipient is at risk of severe harm to self or others because of problems negotiating the basic environment (i.e., loose associations, paranoia, hallucinations, delusions, other forms of thought disorder). Indicators include: disruption of safety to self, family, peer or community group; impaired reality testing sufficient to prohibit participation in school or vocational pursuits; not responsive to outpatient trial of medication or supportive care; requires inpatient diagnostic evaluation to determine treatment needs.
 - **Severely dysfunctional patterns:** Familial, environmental, or behavioral processes that place the recipient at risk. Indicators: Family environment is causing escalation of recipient's symptoms or places him at risk; The family situation is not responsive to outpatient or community resources and intervention; Instability or disruption is escalating; The situation does not improve with the provision of economic or social resources; Severe behavior problems prohibit any participation in a less restrictive level of care (e.g., acutely sexualized behavior, risk of running away, impairing safety, repeated substance abuse, etc.)

Criterion C: The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. To meet this requirement, BOTH of the following conditions must be met.

1. The treatment provider describes a treatment plan showing how the recipient's condition is expected to either improve, or prevent risk of regression and possible impairment of safety, such as would be caused by discharge without immediate accessibility or availability to an appropriate placement in a lower level of care.
2. Active daily measures are diligently taken by staff to develop and implement an appropriate lower level of care. The details of these active measures are given during the Prior Authorization reviews, and are documented in the daily progress notes in the charts.

DETERMINING MEDICAL NEED FOR ACUTE SERVICES

A – C must be met for discharge from an acute inpatient psychiatric services.

Criterion A: Resources providing less restrictive levels of care are available and accessible and will meet the treatment needs of the recipient. (examples are below)

- Family or relative placement with outpatient therapy
- Day or after-school treatment
- Therapeutic Foster care
- Group child care supported by outpatient therapy
- Other Clinical or Rehabilitative Services
- Residential Treatment

Criteria B: Proper treatment of the recipient's psychiatric condition can be met on an outpatient basis. To meet this requirement all of the following requirements must be met:

1. The recipient is not experiencing problems related to the mental disorder in the following categories below.
 - **Self-care (age appropriate):** The recipient is able to meet basic needs for nutrition, sleep, hygiene, rest, or stimulation.
 - **Safety:** Within the past 24 hours, the recipient has not exhibited gestures of harm to self or others.
 - **Thought and/or perceptual processes (reality testing):** The recipient has demonstrated an ability to perceive and validate reality sufficient to negotiate the basic environment.
2. The treatment team has developed a plan of treatment that can be met in an outpatient level of care.

Criterion C: The outpatient services can reasonably be expected to improve the recipient's condition or prevent further regression.

Acute Continued Stay Review Criteria

For continued acute inpatient stays in a psychiatric hospital or an inpatient psychiatric program in a hospital to be authorized, criteria in Sections A, B, and C must be met. If the primary need for inpatient care is substance dependency, proceed to Acute Inpatient for Substance Dependency Hospitalizations.

Criteria for Acute Inpatient CSR (Non-Substance Dependency Admissions)

Criterion A: Ambulatory care resources in the community do not meet the treatment need of the individual –and- a minimum of one of the following is established:

<p>1. A lower level of care is unsafe and will place the recipient at risk for imminent danger of harm. Examples of lower level care include:</p> <ul style="list-style-type: none"> • Family or relative placement with outpatient therapy • Day or after-school treatment • Foster care with outpatient therapy • Therapeutic foster care • Group child care supported by outpatient therapy • Therapeutic group child care • Partial hospitalization • Residential setting 	<p>2. Clinical evidence that a lower level of care will not meet the recipient's treatment needs. For example:</p> <ul style="list-style-type: none"> • Patient's behavior persists despite therapeutic interventions in a lower level of care, placing the recipient at risk of serious harm or making treatment in a lower level of care unsafe. 	<p>3. The recipient's mental disorder could be treated with a lower level of care; but because the recipient suffers one or more complicating concurrent disorders, inpatient care is medically necessary at a higher level of care. Examples include:</p> <ul style="list-style-type: none"> • Major depression with epilepsy • Major depression with unstable insulin dependent diabetes • Major depression with renal dialysis
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DETERMINING MEDICAL NEED FOR ACUTE SERVICES

Criteria B: Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. To meet this requirement all of the following requirements must be met:

<p>1. The patient has a psychiatric condition or disorder which is classified as a DSM-IV diagnosis (neither substance abuse nor rule-out conditions qualify under this criterion).</p>	<p>4. The treatment team has updated the initial plan of treatment and has identified clinical evidence that continued intensive services are still required at an inpatient psychiatric level of care; specifically</p> <ul style="list-style-type: none"> ● Services shall be under the supervision of a psychiatrist ● Intervention of qualified professionals shall be available 24-hours per day ● Multiple therapies (group counseling, individual counseling, recreational therapy, family therapy, etc.) shall be actively provided to the recipient
<p>2. The rating on DSM-IV Axis V continues to be 50 or less. However, Axis V rating will be used as the basis for denial only if critical to establish the need for inpatient psychiatric hospital treatment.</p>	
<p>3. The recipient is currently experiencing problems related to the mental disorder diagnosis in number one (1) above and at least one (1) of the following categories below.</p> <p style="margin-left: 40px;">a. Self-care deficit (not age related): Impairment of ability to meet physical needs which place the recipient at risk of serious self-harm. Indicators:</p> <ul style="list-style-type: none"> ● Self-care deficit severe and long-standing enough to make participation in an alternative setting in the community unsafe ● Self-care deficit places recipient in life threatening psychological imbalance without 24-hour medical nursing intervention and supervision (examples: dehydration, starvation states, exhaustion due to extreme hyperactivity) <p style="margin-left: 40px;">b. Impaired safety (threat to self or others): Continued evidence of serious intent to harm self or others caused by the recipient's mental disorder. Indicators:</p> <ul style="list-style-type: none"> ● Continued suicidal/homicidal ideation with expression of serious plan of intent ● Continued violent or aggressive behavior requiring seclusion or restraints <p style="margin-left: 40px;">c. Impaired thought and/or perceptual processes (reality testing): Inability to perceive and validate reality to the extent that the patient cannot negotiate his basic environment, nor participate in family or school (e.g., due to paranoia, hallucinations, delusions) and it is likely that the recipient will suffer serious harm. Indicators:</p> <ul style="list-style-type: none"> ● Disruption of safety of self, family, peer or community group ● Impaired reality testing sufficient to prohibit participation in any community educational alternative ● Not responsive to outpatient trial of medication ● Requires inpatient diagnostic evaluation to determine treatment needs <p style="margin-left: 40px;">d. Severely dysfunctional patterns: Family, environmental, or behavioral processes which place the recipient at risk of serious harm without intensive medical monitoring. Indicators (one (1) of the following):</p> <ul style="list-style-type: none"> ● Family environment is causing escalation of recipient's symptoms or places recipient at risk ● The family situation is not responsible to available outpatient intervention ● Instability or disruption is escalating ● Severe behavior prohibits any participation in a lower level of care 	

DETERMINING MEDICAL NEED FOR ACUTE SERVICES

Criterion C: The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

1. The treating facility shall have developed a plan for continuing treatment illustrating the required intensity of services available at an inpatient psychiatric level of care.	2. The treating facility shall provide a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan shall be initiated as soon as the initial assessment is completed and shall include discrete, behavioral and time-framed discharge criteria with documentation of referral to outpatient providers for placement and identified aftercare services.	3. There is evidence that discharge to available community resources will likely result in exacerbation of the mental disorder to the degree that continued hospitalization would be required or would result in regression.
4. Available clinical and research data supports the likelihood of positive outcome from inpatient psychiatric treatment for the patient's diagnosis and presenting symptoms.		

Criteria for Acute Inpatient CSR (Primary Substance Dependency Admissions)

Criterion A: Ambulatory care resources in the community do not meet the treatment need of the individual –and- a minimum of one of the following is established:

<p>1. A lower level of care is unsafe and will place the recipient at risk for imminent danger of harm. Examples of lower level care include:</p> <ul style="list-style-type: none"> • Family or relative placement with outpatient therapy • Day or after-school treatment • Foster care with outpatient therapy • Therapeutic foster care • Group child care supported by outpatient therapy • Therapeutic group child care • Partial hospitalization • Residential setting 	2. Clinical evidence that a lower level of care will not meet the recipient's treatment needs.
---	--

Criteria B: Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. To meet this requirement all of the following requirements must be met:

1. The patient has a substance dependency disorder which is classified as a DSM-IV diagnosis (neither substance abuse nor rule-out conditions qualify under this criterion).	<p>3. The treatment team has updated the initial plan of treatment and has identified clinical evidence that continued intensive services are still required at an inpatient psychiatric level of care; specifically:</p> <ul style="list-style-type: none"> • Services shall be under the supervision of a psychiatrist • Intervention of qualified professionals is available 24-hours per day • Multiple therapies (group counseling, individual counseling, recreational therapy, family therapy, etc.) will be actively provided to the recipient
<p>2. The recipient is currently experiencing problems related to the substance disorder diagnosed in number one (1) above in at least (2) two of the following categories below:</p> <ol style="list-style-type: none"> a. Evidence of signs and symptoms of withdrawal which continue to require 24-hour medical nursing intervention. b. Persistent Biomedical conditions and complications in addition to signs and symptoms of withdrawal which would place the recipient at risk of life-threatening consequences within 24-hour medical nursing care. To meet this criterion, at least one (1) of the following must be 	

DETERMINING MEDICAL NEED FOR ACUTE SERVICES

Criteria B: Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. To meet this requirement all of the following requirements must be met:

present:

- Continued imminent danger of serious damage to physical health for concomitant biomedical conditions (e.g., pregnancy, hepatic decompensation, acute pancreatitis, gastrointestinal bleeding, cardiovascular disorders)
- Continued life-threatening symptomatology related to excessive use of alcohol or other drugs (e.g., stupor, convulsions, etc.)
- c. Emotional/Behavioral conditions and complications - one (1) of the following:
 - Continued risk of behaviors endangering self or others (e.g., current suicidal/homicidal thoughts)
 - Presence of violent or disruptive behavior with imminent danger to self or others
 - Altered mental status with or without delirium as manifested by disorientation to self; alcohol hallucinosis, or toxic psychosis

Criterion C: The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

1. The treating facility must have developed a plan for continuing treatment illustrating the required intensity of services available at an inpatient level of care.	2. The treating facility must provide a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan will be initiated as soon as the initial assessment is completed and will include discrete, behavioral and time-framed discharge criteria with documentation of referral to outpatient providers for placement and identified aftercare services.	3. Available clinical and research data supports the likelihood of positive outcome from inpatient psychiatric treatment for the patient's diagnosis and presenting symptoms.
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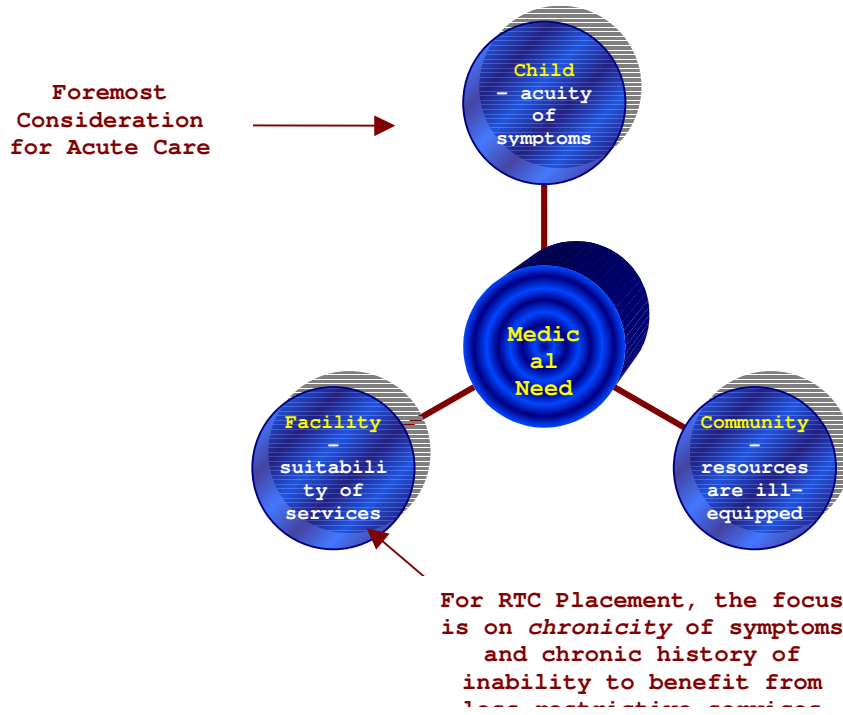
Though not specifically a function of utilization criteria, determinations must consider quality of care issues in addition to medical necessity in order to arrive at a decision regarding suitability of treatment for a particular child. These standards are further defined through operational criteria reflecting individual's psychopathology, historical psychiatric indicators, diagnostics, and impairments resultant from current symptoms. While the basic domains are the same for both RTC/ARTC and inpatient psychiatric care, the locus of decision making for acute decisions is most heavily influenced by symptom acuity.



***Note about Judicial Orders for Treatment**

While judicial processes oftentimes order treatment as a result of criminal activity, a court order is not a sole determinant for Medicaid reimbursement for acute or residential services. Medical Assistance will not pay for services that are not medically appropriate, regardless of criminal justice involvement as a precipitator for treatment.

Domains of Consideration for Determinations



If a child's condition improves prior to the conclusion of the authorized period, it is the responsibility of the provider to initiate discharge.

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Section
4

General Information

Reconsiderations and Appeals

Appeal Process

Desk reconsideration and appeal processes are recourse opportunities for providers who disagree with adverse determinations.

Desk Reconsideration: A desk reconsideration allows the facility to submit information not previously submitted that may justify medical necessity of the recipient's treatment.

Appeal: A request from a recipient or his authorized representative to disagree with a denial for services and the opportunity to present his case to a reviewing authority.

DESK RECONSIDERATION

The *Desk Reconsideration Process* occurs as follows:

- The provider contacts DDM by phone, facsimile, or e-mail within ten (10) calendar days of the written notification.
- DDM will request that the provider submit any additional information disputing the basis for denial and copies of specific medical records.
- DDM's Board-certified/eligible child psychiatrist will complete the desk reconsideration within two (2) business days of receipt of the clinical information.
- The physician who made the initial determination will perform the desk reconsideration whenever possible. Notification of all final determinations will include rationale for the determination based upon the applicable federal and State regulations, and include instructions as to the rights of further appeal.

If the desk reconsideration review upholds the adverse determination, the option to appeal remains available for the recipient and/or parent or legal guardian of the recipient as indicated in the initial determination. The Department is not responsible for payment to the provider for

GENERAL INFORMATION

services provided to the recipient during desk reconsideration. If the outcome of the desk reconsideration reverses the denial, payment for services will be retroactive to the date of the disputed denial.

Written notification will be forwarded to the provider, recipient, and/or parent or legal guardian of the recipient related to the outcome of the desk reconsideration.

A P P E A L

For Acute Inpatient Under 21 Providers and Accredited RTCs receiving Title XIX funding for room and board and treatment services, the Department is not responsible for payment to the provider for services provided to the recipient during an appeal. If the outcome of the appeal reverses the denial, payment for services will be retroactive to the date of the disputed denial.

Recipients and/or parents and legal guardians of recipients may request an appeal via a written request to the North Dakota Department of Human Services within 30 calendar days of the initial denial determination notification.

Appeal Requests must be made in writing to:

Appeals Supervisor
North Dakota Department of Human Services
Department 325
600 E. Boulevard Avenue
Bismarck, ND 58505-0250

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Appendix A: Instructions for Completing the Admission Review Form

Prior Inpatient Treatment: Provide complete information regarding prior inpatient and RTC episodes, including dates of treatment (admission and discharge), treating facility, reason for admission, etc.

Prior Outpatient Treatment: Provide complete information regarding previous outpatient episodes, including: date of admission and discharge, treating facility, reason for treatment, etc.

Initial Treatment/Discharge Plan: Provide treatment goals as well as attendant interventions and their frequency. A description of the plan for treatment must illustrate that the level of intensity of services is required at the inpatient psychiatric level of care.

Estimated Length of Stay: Identify anticipated length of stay.

Admitting Diagnoses: Axis I-Axis V must be completed according to criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised (DSM-IVR). Indicate *none* or *deferred* as applicable. Axis IV must reflect psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of the mental disorder through initiating or exacerbating that disorder, as a consequence of the psychopathology of the disorder, or as a problem that should be considered in the overall management plan for the recipient. Axis IV conditions should be noted only as relevant and only those present during the year preceding the current evaluation should be listed. Axis IV conditions must be fully explained. Axis V, Current Global Assessment of Functioning (CAF) must rate the recipient with respect to psychological, social and occupational functioning, not including impairment in functioning due to physical or environmental limitations. Ratings should be provided according to GAF criteria as provided in the DSM-IVR and should reflect the recipient's functioning at the time of the admitting evaluation. The Historical Global Assessment of Functioning (HAF) should reflect the recipient's highest level of functioning during the previous one year period.

Medications: List prescription medications used to treat the recipient's psychiatric condition, listing drug dosages, purposes, and dates used. Include all psychoactive medication used during the preceding one year period. Specify, where applicable, medications that have been discontinued as well as medications currently prescribed.

Precautions: Document precautions and frequency of checks, if applicable. Note the purpose of the precautions (e.g., elopement versus monitoring as a result of suicidality).

Current Symptoms Requiring Inpatient Care: Thoroughly document presence, severity, and nature of all relevant psychiatric symptomatology and behaviors present immediately preceding and at the time of the admitting evaluation. Where applicable, documentation must thoroughly explain presence, or absence, of relevant deficits in the following areas: severe self care deficit, impairment to safety of self or others with documentation of threats accompanied by criteria provided in criteria in this manual, impaired thought processes, severely dysfunctional patterns. Include a description of any related adverse familial or social circumstances.

Chronic Behavior: Thoroughly document symptoms/behaviors present during the preceding twelve months prior to the admitting evaluation. Include a description of social adjustment related to familial, educational, and other relevant spheres of life. Include a complete description of prior suicidal and/or homicidal threats or gestures.

Appendix B: Instructions for Completing the Continued Stay Review Form

Estimated Length of Stay: Identify date of expected discharge based upon clinical evaluation of recipient's acuity and estimated expectations of improvement. In the event that the recipient's estimated discharge extends beyond discharge projections reported at the previous certification, provide an explanation as to the rationale for extending care.

Revised On: Identify date of continued stay request. The completed continued stay request must be received by DDM within one business day of the end date from the previous certification.

Change in Diagnosis: Provide Axis I-V diagnoses which have changed or been modified since the previous certification. *Global Assessment of Functioning (GAF)* is required for every certification request.

Psychiatric Medication Changes: Provide drug name, dosage, purpose, and dates for any physician ordered behavioral/psychiatric medications.

Precautions/Frequency of Checks: Identify any precautions, the basis for precautions, and frequency of monitoring.

Discuss Selection: Describe the basis for the selected criteria.

Describe Symptoms/Progress from Last Certified Date: Describe the continued presenting symptoms observed since the prior authorization date. Progress (and lack of) with treatment must be fully explained.

Discuss Treatment Plan Goals: Describe the plan for continuing treatment, dates of plan changes, and updates to the treatment plan since the last review.

Discuss Service Intensity: Describe the treatment services provided to the recipient since the last certified stay.

Tentative Discharge Plan: Rationale for an extension must be provided if the tentative discharge date has been extended since the previous authorization.

Appendix C: Forms

Admission Review Form

Continued Stay Review Form

Retrospective Review Request Form

Provider Certification of Need Form

ADMISSION REVIEW FORM

CSR REVIEW FORM



North Dakota Retrospective Review Request Form

Date: _____

To: Dual Diagnosis Management (DDM)
ND Under 21 Review Team
220 Venture Circle
Nashville, Tennessee 37228

Re: Recipient Name _____ DOB _____

Facility/Provider _____

Facility Address _____

City _____ State _____ Zip _____

County _____ Fax _____ Phone _____

Type of Review Requested (care provided): ☐ Residential ☐ Acute

I am requesting retrospective review of the above named individual who has applied for Medicaid benefits following receipt of treatment services. I am enclosing the complete medical record.

Signature of Provider Representative: _____

Printed Name: _____ Credentials: _____

Certification of Need Form ~ Acute Inpatient Hospitalization for Individuals Under Age 21

Patient Information

Recipient's Name _____

Medicaid ID Number _____

Date of Birth _____ Age _____ Gender _____

The Team Responsible for the Plan of Care Certifies the Following:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient due to:

2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician due to:

3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed based upon:

Signature of Physician Team Member

Signature of Other Team Member

Signature of Other Team Member

Print/Type Name

Print/Type Name

Print/Type Name

Date: _____

Date: _____

Date: _____

Title: _____

Title: _____

Title: _____

NDCONPROVIDER 6/17/03